

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services – Region IV
Sam Nunn Atlanta Federal Center
61 Forsyth Street, SW, Suite 4T20
Atlanta, Georgia 30303 - 8909

June 20, 2001

Dear State Program Integrity Contacts:

As you may be aware, the Health Care Financing Administration (HCFA) has been recently re-named to the Centers for Medicare and Medicaid Services (CMS). The CMS' Comprehensive Plan for Program Integrity sets forth our goals to pay the right amount, to a legitimate provider, for covered services, provided to an eligible beneficiary. Inherent in our Comprehensive Plan is our responsibility to support States' program integrity efforts.

In August 1997, the Southern Consortium, the lead for the National Medicaid Fraud and Abuse Initiative, hosted a focus group in Atlanta. The purpose of the focus group was to have States tell us how to best assist them as an active partner in controlling fraud and abuse in the Medicaid program. In response to priorities set by States, the National Medicaid Fraud and Abuse Team developed the 10 goals that comprise the National Medicaid Fraud and Abuse Initiative. One of these goals was to enable States to get complete and accurate information on Medicare policy, providers and beneficiaries to control fraud and abuse involving dual eligibles. To that end, we are sending you information that may be helpful in administering benefits for dually eligible beneficiaries.

Fraud Investigation Database

CMS is making the Fraud Investigation Database (FID) more accessible to States. The FID is a comprehensive nationwide system devoted solely to the accumulation of Medicare fraud and abuse data and is currently accessible by CMS program integrity staff, its contractors, some State Medicaid Surveillance and Utilization Review staff, Medicaid Fraud Control Units and Federal law enforcement agencies. CMS is committed to making the FID a more efficient and effective tool for the States by allowing for the inputting and tracking of Medicaid cases as part of a major redesign that is currently under development.

This database redesign project involves developing, testing, documenting, and implementing a user-friendly computer system which will provide the current status of all Medicare and Medicaid fraud cases, a chronology of events from the initial complaint through the final resolution, and documentation of those fraud cases referred internally and externally to law enforcement agencies.

The new FID is scheduled to be completed by October 1, 2001. Under this redesign, all Medicaid State agencies and appropriate users (e.g., Medicaid fraud investigators) will be able to input, browse, and produce reports on Medicaid cases throughout the United States. In addition, Medicaid users will be able to query the FID to identify possible trends that are applicable to Medicaid services. Questions regarding the FID

should be directed to Mark Rogers in the CMS Atlanta Regional Office at 404-562-7321.

Medicare Policy and Operating Procedures

Under the Dual Eligible Goal, States identified an interest in being able to access Medicare law, Medicare regulations, and the operational procedures of the Medicare intermediaries and carriers. Having access to this information will assist States in administering claims for dually eligible beneficiaries and in the post-payment analysis that is a critical component of anti-fraud and abuse efforts.

The Medicare law, Title XVIII of the Social Security Act, and the Medicare regulations, which are found in Title 42 of the Code of Federal Regulations, are easily accessible at CMS' web site at: <http://www.hcfa.gov/regs>. CMS' instructions to intermediaries and carriers can be found at:

<http://www.hcfa.gov/pubforms/progman.htm>. The Medicare Intermediary Manual and the Medicare Carriers Manual, which are found at this address, contain detailed instructions regarding the services covered under the Medicare program and the requirements for Medicare contractors to review claims. A Medicare Coverage Issues Manual is also available at this web site. This manual contains national coverage information on diagnostic and treatment procedures and on medical equipment and supplies. The Provider Reimbursement Manual is also available at this web site and contains information on reimbursement methodologies for institutional-type providers as well as cost report forms.

The Medicare Program Integrity Manual contains instructions to Medicare contractors regarding medical review and fraud detection activities, and can be found at: http://www.hcfa.gov/pubforms/83_pim/pim83toc.htm.

Local Medical Review Policy

Medicare contractors develop and implement local medical review policy (LMRP). The development of LMRP is a consultative process involving review by the medical community. Typically, there is a Carrier Advisory Committee (CAC) which facilitates clinical input and an open exchange of information. Since States have indicated an interest in being consulted about Medicare policy while it is in the development stage, States should advise their local Medicare contractor if they are interested in formally participating on the CAC.

A single web site address <http://www.lmrp.net> allows access to all Medicare contractor LMRPs. As of the May 25, 2001 update, the web site contains all the LMRPs submitted by Medicare contractors as of April 30, 2001. The web site will be updated on a monthly basis.

Identification of Medicare Providers

Currently, CMS has in place three sources of information on participating Medicare providers that may be helpful to States. First, providers that are certified for program participation by CMS (which include hospitals, skilled nursing facilities, home health agencies, end stage renal disease facilities, portable x-ray units, rural health clinics, outpatient rehabilitation facilities, hospices, Clinical Lab Improvement

Amendments (CLIA) labs, community mental health centers and ambulatory surgical centers) have information about them in the Online Survey Certification and Reporting System (OSCAR). OSCAR is a mainframe system used for maintaining current survey and certification status of these certified providers. Any State that does not currently have access to this information should contact its respective CMS regional office regarding their interest and information needs.

Second, the Unique Physician Identifier Number (UPIN) was created as a result of the Consolidated Omnibus Budget Reconciliation Act of 1985. That law mandated that a unique identifier be issued to each physician, regardless of his or her practice configuration, i.e., solo practitioner, partner, or group practice. Since then, the system has been expanded to include all health care practitioners and group practices. These include: physicians, physician assistants, certified nurse midwives, psychologists, nurse practitioners, clinical social workers, physical, occupational and respiratory therapists and certified registered nurse anesthetists. The UPIN is a randomly assigned unique 6-place alpha/numeric base number to identify the practitioner and group and a 4-place location identifier to identify the billing and practice setting. The UPIN Directory is compiled on CD-ROM and may be purchased from the Government Printing Office, Superintendent of Documents at (202) 512-1800. It is also available at the web site: <http://www.cpg.mcw.edu>.

Suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) enroll in Medicare through the National Supplier Clearinghouse (NSC), which is the third source of information about Medicare providers. The NSC maintains a file of DMEPOS suppliers and their current status in Medicare, including adverse actions taken against them. Information on how to access this information may be obtained from Mr. Charles Waldhauser, Division of Provider and Supplier Enrollment, Program Integrity Group, Office of Financial Management, CMS at (410) 786-6140 or at cwaldhauser@hcfa.gov.

We support the continued participation of States in regularly scheduled meetings with law enforcement officials and government insurers to discuss anti-fraud initiatives and emerging trends. Similarly, we encourage States and Medicare contractors to meet on an ongoing basis to discuss issues of interest and to resolve information needs. Any State needing assistance in obtaining information should contact its respective regional office staff. We are firmly committed to combating fraud and promise to continue our work with States to address the unique issues surrounding dually eligible beneficiaries in the Medicaid program.

If you have any questions regarding this information, please contact the regional Medicaid fraud and abuse coordinator in your respective CMS regional office.

Sincerely,

/s/

Rose Crum-Johnson
Southern Consortium Administrator

cc:
CMS Associate Regional Administrators for Medicaid and State Operations

CMS Associate Regional Administrators for Financial Management and Program Integrity

Director, Center for Medicaid and State Operations

Director, Program Integrity Group, Office of Financial Management

Consortium Contractor Management Officers